MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

CERTIFICATE OF DEATH

* 10036

Reg. Dist. No. 1721

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Garrett

City or town: Rural near Oakland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: GORMAN R.D. Route #1 Gormania, W. Va.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 6 months -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pennsylvania County:

City or town: McClure Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME: Samuel Hoffman

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 26 1859

8. AGE:

Years	Months	Days	If less than one day
87	11	8	hrs. min.

9. Birthplace: West Beaver Township, Snyder Co., Pa.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Peter Hoffman
13. Birthplace: Germany

MOTHER
14. Maiden name: Elizabeth Roger
15. Birthplace: Virginia

16. Informant: Mrs. Marshall Harvey
Address: Gormania, W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 21, 1946 (month) (day) (year)

Cemetery or crematory: Samuels Church Cemetery

Location: McClure, Penna.

18. Funeral director: Otha F. Sharpless
Address: Blaine, W.Va.

19. Oct 19 19 A.W. Barrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18 1946, at 5A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1943, to 10/18 1946, and that I last saw him alive on June 28 1946.

	DURATION
Immediate cause of death: Cerebral hemorrhage at base of brain	2 wks
Due to Hypertension + arterio-sclerosis	10 yrs
Due to Senility	
Other conditions: Gangrene of chronic ulcer on toe (rt great)	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

Of autopsy: Not done -

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Harold C. Miller M.D.
M. D. or other

Address: Eglon, W.Va. Date signed 10/18/46

2-25

2-1720 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52)

10037

CERTIFICATE OF DEATH

Reg. Dist. No. 167

1. PLACE OF DEATH:
County Garrett
City or town Rural Oakland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 74 yrs.
Hospital, institution, or street address where death occurred:

How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Garrett
City or town Rural Oakland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 10 Mi. South Oakland
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Caroline Rose Shaffer Janoske

3.(b) Social Security Number -----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Karl Janoske
6.(c) If alive, give age ---

7. Birth date of deceased (mo., day, yr.) December 10, 1851

8. AGE: Years	Months	Days	If less than one day
94	9	21	.....hrs. .....min.

9. Birthplace Aurora; Preston Co., W. Va. (Town, county, and state)
10. Usual occupation House Wife
11. Industry or business Own Home
FATHER 12. Name Frederick Shaffer
13. Birthplace Germany
MOTHER 14. Maiden name Unknown
15. Birthplace
16. Informant Greely Janoske
Address R. D. Oakland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 4, 1946 (month) (day) (year)
Cemetery or crematory Red House Cemetery
Location 9 Mi. South Oakland
18. Funeral director Herbert C. Leighton
Address Oakland, Md.
19. 10/4 1946 (Date rec'd by registrar) Elmer C. Shaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1946, at 5:15A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from intermittently 1933, to October 1 1946 and that I last saw her alive on September 30 1946

Immediate cause of death	DURATION
Dehydration, anemia.	1 wk.
Due to Hematuria	2 wks.
Due to Carcinoma of bladder ?? or kidney?	1 yr.
Other conditions Marked senility.	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harold C. Miller M.D. M. D. or other
Address Eglon, W. Va. Date signed 10/2/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

Evidence for the addition of items 4& 5 are shown on

10456

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-d)

FILM No. I 08 DEC 24 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 1610

1. PLACE OF DEATH:
County Garrett
City or town near Friendsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Garrett
City or town near Friendsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Julia A. Lint

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	

6.(b) Name of husband or wife Calvin Lint
6.(c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) Mch 1863

8. AGE: Years 78 | Months 8 | Days 22 | If less than one day ... hrs. ... min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Isaac Tinney
13. Birthplace Md

MOTHER 14. Maiden name Myers
15. Birthplace Md

16. Informant Calvin Lint
Address Friendsville Maryland

17. Burial (Burial, ~~cremation~~, Which?) Date thereof Oct 6-46 (month) (day) (year)
Cemetery or crematory Grace Ridge
Location near Friendsville

18. Funeral director W. H. Savage
Address Friendsville Md

19. Oct 6 1946 (Date rec'd by registrar) Kathryn Fike. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1946, at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13, 1946, to Oct 4, 1946
and that I last saw h ER alive on October 4, 1946

Immediate cause of death	DURATION
CARCINOMA Rt. LUNG	6 Mo
Due to	
Due to	
Other conditions CHRONIC MYOCARDITIS	2 YRS

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Milton Jeffers, M.D.
M. D. or other
Address FRIENDSville, Md Date signed Oct 5, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

Dr P E Berry 10038

CERTIFICATE OF DEATH

Reg. Diat. No. 163

1. PLACE OF DEATH:

County Garrett

City or town Bloomington (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County ~~XXXXXXX~~ Garrett

City or town Bloomington (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Thomas Wilson McDowell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Eva Warnick McDowell

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 11, 1888

8. AGE: Years	Months	Days	If less than one day
57	10	3	..... hrs. ..... min.

9. Birthplace Burlington, Mineral, W. Va. (Town, county, and state)

10. Usual occupation Merchant

11. Industry or business Feed Store

FATHER 12. Name Joseph McDowell

13. Birthplace unknown

MOTHER 14. Maiden name Sarah McLamar

15. Birthplace unknown

16. Informant George McDowell

Address Bloomington, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof Oct 16, 1946 (month) (day) (year)

Cemetery or crematory Philos Cemetery

Location Westernport, Md.

18. Funeral director Ellsworth S. Boal

Address 111 Church St., Westernport, Md

19. Oct. 16 1946 Dorsey Pattison (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1946 at 4:45a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 9 1946 to October 14 1946 and that I last saw h.. alive on October 13 1946

Immediate cause of death	DURATION
Chronic Nephritis	1 yr
Hypertension	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P E Berry M. D. or other

Address Piedmont W Va Date signed Oct 16-46

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

10457

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1610

1. PLACE OF DEATH:
County: Garrett
City or town: Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? No

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Garrett
City or town: R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ida Belle Umbel

3.(b) Social Security Number: None

4. Sex: F.
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Lloyd Umbel deceased
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): May 14 1868
8. AGE: Years 78 Months 5 Days 9 If less than one day ..... hrs. ..... min.
9. Birthplace: Md (Town, county, and state)
10. Usual occupation: House Keeper
11. Industry or business: None.
12. FATHER Name: Wm. R. Barnhouse
13. FATHER Birthplace: not known
14. MOTHER Maiden name: Polly Fike
15. MOTHER Birthplace: Md.
16. Informant: Mr Wm Umbel
Address: Friendsville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: oct 25-46 (month) (day) (year)
Cemetery or crematory: Asher Island Cemetery
Location: Friendsville Md. Rural
16. Funeral director: H.T. Rohrbaugh
Address: Markleysburg Pa
19. Oct 23 1946 (Date rec'd by registrar) Kathryn Fike. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 23- 1946, at 5:15 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 19..... to Oct. 23- 1946
and that I last saw her alive on Oct- 21 1946

	DURATION
Immediate cause of death: Mitral Stenosis	2 yrs 1
Due to:	
Due to: Senility & Hypostatic Pneumonia	9 1 24 hrs.
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: N. B. Mearnore M.D. M. D. or other
Address: Addison - Pa. Date signed: 10/23/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

10039

Reg. Dist. No. 166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County: Garrett
City or town: Mt. Lake Park Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4- weeks
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Mt. Lake Park, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2 Mi, South of Mt. Lake Park Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Emily Harvey Welch

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Clifford Welch
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): December, 15, 1876

8. AGE: Years	Months	Days	If less than one day
69	10	10	hrs. min.

9. Birthplace: Garrett County, Maryland. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home

FATHER
12. Name: William Harvey
13. Birthplace: Garrett Co, Md.

MOTHER
14. Maiden name: Hester Wilson
15. Birthplace: Garrett Co. Md.

16. Informant: Clifford Welch
Address: Mt. Lake Park Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October, 27, 1946 (month) (day) (year)
Cemetery or crematory: White Church Cemetery
Location: 5 Mi- S.E. Mt. Lake Park Md.

18. Funeral director: Herbert C. Leighton
Address: Oakland. Md.

19. 10/27/ 19 46 (Date rec'd by registrar) Judia A. Rowan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October, 24, 19 46 1:30. A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct, 23, 19 46 to 19 and that I last saw her alive on October, 23. 19 46

Immediate cause of death	DURATION
Cardiac Failure	
Ventricular Flutter	
Due to: Arterio sclerosis, myocorditis	
Due to:	
Other conditions: Heart failure bilat	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. G. Gannon M.D. M. D. or other
Address: Oakland Md. Date signed: 10/26/46